



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Kevin Landry, D.C.

Respondent Name

Lion Insurance Company

MFDR Tracking Number

M4-17-0752-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

November 16, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THE CURRENT RULES ALLOW REIMBURSEMENT"

Amount in Dispute: \$650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 3, 2016	Designated Doctor Examination	\$650.00	\$650.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.210 sets out the procedures for medical documentation.
3. 28 Texas Administrative Code §133.210 sets out the procedures for payment or denial of medical bills.
4. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services from March 1, 2008 until September 1, 2016.
5. No claim adjustment reason codes were provided on the submitted Explanation of Benefits.

Issues

1. Did Lion Insurance Company respond to the medical fee dispute?
2. Did Lion Insurance Company request additional information in accordance with 28 Texas Administrative Code §133.210?
3. What is the recommended reimbursement amount for services in question?

Findings

1. The Austin carrier representative for Lion Insurance Company (Zurich) is JT Parker and Associates, LLC. JT Parker and Associates, LLC acknowledged receipt of the copy of this medical fee dispute on November 21, 2016.

28 Texas Administrative Code §133.307 states, in relevant part:

- (d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
 - (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days after the date the respondent received the copy of the requestor's dispute** [emphasis added]. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

Review of the documentation finds that no response has been received from JT Parker and Associates, LLC to date. The division concludes that the carrier failed to respond within the timeframe required by §133.307(d)(1). For this reason, the division will base its decision on the information available.

2. Kevin Landry, D.C. is seeking reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating performed on March 3, 2016. An Explanation of Benefits (EOB) dated June 7, 2016 was submitted with the Medical Fee Dispute Resolution Request (DWC060).

The submitted EOB states, "IN ORDER TO ANALYZE THE ATTACHED BILLING, IN COMPLIANCE WITH RULE 133.240, WE WILL NEED THE FOLLOWING INFORMATION FROM YOUR FILES: Please resubmit with a copy of the form CMS-1500 along with the W-9." The process for a carrier's request for documentation not otherwise required by 28 Texas Administrative Code §133.210 is described in Subsection (d) as follows:

Any request by the insurance carrier for additional documentation to process a medical bill shall:

- (1) be in writing;
- (2) be specific to the bill or the bill's related episode of care;
- (3) describe with specificity the clinical and other information to be included in the response;
- (4) be relevant and necessary for the resolution of the bill;
- (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
- (6) indicate the specific reason for which the insurance carrier is requesting the information; and
- (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation.

No documentation was found to support that the carrier made an appropriate request for additional documentation with the specificity required by §133.210(d). The division concludes that carrier failed to meet the requirements of 28 Texas Administrative Code 133.210(d).

3. Per 28 Texas Administrative Code §134.204(j)(3), "The following applies for billing and reimbursement of an MMI evaluation... (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350." The submitted documentation supports that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is \$350.00.

Per 28 Texas Administrative Code §134.204(j)(4), "The following applies for billing and reimbursement of an IR evaluation. ... (C)(ii) The MAR for musculoskeletal body areas shall be as follows. ... (II) If full physical evaluation, with range of motion, is performed: (-a-) \$300 for the first musculoskeletal body area." The

submitted documentation supports that the requestor provided an impairment rating, which included a musculoskeletal body part, and performed a full physical evaluation with range of motion of the right shoulder. Therefore, the correct MAR for this examination is \$300.00.

The total MAR for the services in question is \$650.00. Documentation does not support that a denial or reduction of payment was submitted to the health care provider in accordance with 28 Texas Administrative Code §133.240. Therefore, Dr. Landry is eligible for reimbursement of \$650.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$650.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$650.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____ Laurie Garnes _____	_____ December 30, 2016 _____
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.